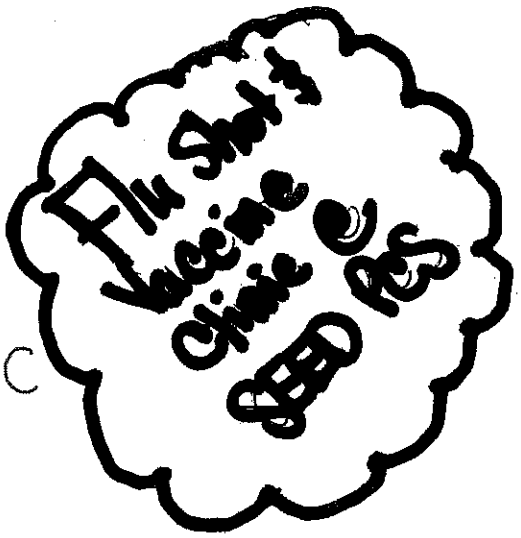
Sunday,
Oct 23, 2016
7p.m. to 9p.m.

Wellness of DC



2141 K Street, NW
Suite 808
Washington, DC 20036

Sign up in the Wellness Suite TODAY!

Dear Parents/Guardians:

Wellness of DC is working with DC Charter Schools to give the annual influenza vaccine to children at school. This vaccine will protect against all three influenza strains that are expected to circulate this year. Wellness of DC will be holding vaccination clinics beginning this fall. Your child's school will let you know the specific dates and times of the clinics and will be sending you more information about the disease and the vaccine.

There will be no cost to you or your child for this vaccine. The School will also be sending you a consent form that will include an option allowing you to either accept or refuse the vaccination for your child. If you refuse, the vaccination will not be given to your child.

If you have any questions about the vaccine or the vaccination clinics being held at your child's school, please call: (202)-827-5370. For more information, please visit www.wellnessofdc.com or visit the CDC's influenza web site at www.cdc.gov/flu/parents. Your child's healthcare provider also may answer your questions about the influenza virus or the vaccine.

Sincerely,
Cassidy Mercier
Director of Operations
Wellness of DC
P: (202)-827-5370
WellnessofDC@gmail.com

FREE

©WELLNESS OF DC, LLC.
2016-2017 "Fight the Flu" Program Annual Influenza Vaccine Registration CONSENT FORM

*** A COMPLETED CONSENT FORM IS REQUIRED PER EACH PATIENT RECEIVING VACCINATION. PLEASE PRINT LEGIBILY AND COMPLETELY. ***

Section 1: PATIENT INFORMATION
[to be filled out with the information of the person who is to be receiving vaccination]

LAST NAME	FIRST NAME	(M.I.)	DATE OF BIRTH (__/__/__)	AGE	GENDER

MAILING ADDRESS	CITY	STATE	ZIP

EMAIL	PHONE NUMBER	RACE	OCCUPATION

SECTION 2: EMERGENCY CONTACT INFORMATION
[for all patients under the age of 18, Section 2 is to be filled out with the information of the parent or legal guardian of the patient]

LAST NAME	FIRST NAME	(M.I.)	DATE OF BIRTH (__/__/__)	AGE	GENDER

MAILING ADDRESS	CITY	STATE	ZIP

EMAIL	PHONE NUMBER	RELATION TO PATIENT

SECTION 3 (optional): PRIMARY CARE PHYSICIAN INFORMATION

NAME OF PROVIDER	LOCATION OF PRACTICE	PHONE NUMBER

[The patient or his or her legal guardian may request that Wellness of DC share patient records of any immunization(s) received with the patient's primary care physician and/or other healthcare provider(s).]

Section 4: SCREENING FOR VACCINE ELIGIBILITY
The following questions are for screening purposes needed to ensure the patient passes the healthcare criteria needed to receive their annual influenza vaccine.

The following questions are to be answered in reference to the patient whose name is stated above.	YES	NO
1. Has the patient ever had a serious reaction to a flu vaccine?		
2. Does the patient have any severe, life-threatening allergies? If Yes, please list: _____		
3. Has the patient ever had Guillain-Barré Syndrome?		
4. Is the patient feeling well? If No, please explain: _____		
5. Is the patient currently a student enrolled in a Public Charter School in the District of Columbia? If Yes, please state the name of the DC Public Charter School: _____ and the patient's grade level: _____		

Section 3: Insurance Information

Name of Insurance Company:	
Name as appears on Insurance Card:	
Policy holder's date of birth:	Sex: M / F
Insurance Contract or I.D. Number:	☐ Check this box if the patient does not have health insurance

Section 4: CONSENT
I have read or had explained to me the 2015-2016 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ I GIVE CONSENT to Wellness of DC and its staff for the patient named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then your child will not be vaccinated)

☐ I DO NOT GIVE CONSENT to Wellness of DC and its staff for the patient named at the top of this form to be given the vaccine.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian
for Patients under 18: _____ Date: _____